

NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER
NURSING AND PATIENT CARE SERVICES

Standard of Practice: Care of the Patient with Actual or the Potential for Pain

I. ASSESSMENT

- A. Patients are the primary source for information about their recent and ongoing sensations of pain.
- B. When a patient's self-report or other elements of a pain assessment cannot be obtained for any reason (clinical condition, developmental stage, cognitive impairment, etc.), the parent, guardian, or caregiver's report may be obtained and/or objective assessment data collected using a Clinical Center approved pain intensity instrument. This is noted in the medical record.
- C. **Screening for Pain**
 - 1. A patient is screened for pain within 2 hours of inpatient admission, within 1 hour of admission/transfer to a special care unit (SICU, MICU, PACU), or on the initial outpatient visit:
 - a. Is the patient having pain now?
 - b. Is the patient currently being treated for pain?
 - 2. As appropriate, a patient is screened for the presence of pain before, during and after procedures and/or events likely to evoke a pain response, and/or if the patient appears to be in obvious distress.
 - 3. If a patient affirms they are having pain now, the nurse collaborates with the treatment team to provide an appropriate intervention to relieve the immediate discomfort.
- D. **Assessing Pain**
 - 1. If a patient answers in the affirmative to either screening question above, a comprehensive assessment is completed within 24 hours as described below.
 - 2. In the outpatient clinic or the day hospital, the pain assessment conducted by the nurse includes but is not limited to the location of major sites of pain, pain intensity, and effectiveness of currently prescribed pain interventions.
 - 3. When a patient presents to an outpatient or specialty clinic for consultation services and reports pain unrelated to the condition for which the consult is ordered, the location and pain intensity is assessed and then, discussed with the primary treatment team.
 - 4. In the inpatient unit, the pain assessment conducted by the nurse includes the following:
 - a. At each major site of pain identified by the patient, pain intensity is measured (i.e., pain intensity currently, at its worst, at its best, and patient's acceptable level of pain intensity) using an approved pain intensity instrument. To the extent possible, the same intensity instrument is used with each subsequent reassessment.
 - b. The patient's overall description of their pain including but not limited to quality (descriptors), pattern (e.g., onset, duration, and frequency), and what causes and/or relieves pain
 - c. Description of current and previous pain management interventions and their effectiveness.
 - d. Summary of the patient's pain management goals including but not limited to their perception of how their quality of life might be improved.

E. Reassessing Pain

1. In the outpatient clinic or the day hospital, if a patient affirms they are receiving effective pain management, the nurse will reassess pain on a subsequent visit.
2. When a pain intervention is provided to the patient, the nurse reassesses the patient when the onset of action is expected to produce an analgesic effect. Assessments are continued until discharge or until pain interventions are no longer needed.
 - a. Pain location
 - b. Pain intensity
3. If in the professional judgment of the nurse it is not reasonable to reassess the patient's pain within a suggested timeframe (patient is sleeping comfortably, sedated, etc.), it is noted in the medical record.

II. INTERVENTIONS

- A. All scheduled interventions intended to diminish pain are administered unless contraindicated by patient's clinical status or condition. The Licensed Independent Prescriber (LIP) is notified when interventions cannot be administered as ordered.
- B. PRN pain management interventions
 1. Patient-initiated requests for PRN pain management interventions are assessed and appropriate intervention administered.
 2. In the event a patient is unable to initiate a request, e.g., intubated, non-verbal, etc., the RN uses an appropriate pain intensity instrument to objectively determine the need for PRN interventions.
- C. If medical orders for analgesics include a dose or interval range, the nurse may take the following actions:
 1. The initial opioid dose and schedule should be the lowest dose and longest interval permitted within an order that specifies a range of doses and/or administration intervals, unless a greater dose and shorter interval are judged necessary by the evaluating nurse, based on patient's analgesic requirement history, pain presentation, and physical findings.
 2. Within the constraints of a medical order specifying either a range of doses, a range of administration intervals or both, a nurse may increase subsequent doses if it is assessed the response to a previously administered dose was suboptimal. When adequate analgesia follows an opioid dose, but pain recurs before the end of a dosing interval, the administration interval should be decreased.
 3. If a patient's analgesic response to an opioid dose is suboptimal, a nurse may give a supplemental dose earlier than the prescribed administration interval. In such cases:
 - a. A supplemental dose should not be greater than the dose previously administered.
 - b. For range orders, a supplemental dose may be the difference between the maximum dose prescribed and the dose that was suboptimal.
 - (1) If analgesia was suboptimal before a supplemental dose was administered, the initially administered dose may have been insufficient and subsequent doses should be increased within the constraints of the prescribed range.
 - (2) If analgesia was initially adequate, but became suboptimal before the end of the prescribed interval, the interval used may have been too long and should be decreased within the constraints of the prescribed range.
 - c. If the maximum dose specified in a dose range order was given with suboptimal response, a nurse should request orders from an LIP to give a supplemental dose and the patient's analgesic regimen should be reevaluated.
- D. If pain management is unsatisfactory (as determined by the patient and/or objective assessment data), the nurse consults with the primary treatment team to consider a reevaluation of prescribed interventions and/or a consultation by the Pain and Palliative Care Service.
- E. Patient/family education is provided regarding
 1. right to have pain satisfactorily managed
 2. treatment plan and any alternatives

III. DOCUMENTATION

- A. RN documents in approved electronic record or other approved medical record form:
 - 1. Pain screening responses
 - 2. Pain assessment instrument utilized
 - 3. Date and time of assessments, reassessments, interventions, and responses
 - 4. Pt/family education provided
- B. When an element of the pain assessment cannot be completed, it is noted in the medical record.

IV. REFERENCES

- A. Ambuel, B, Hamlett, KW, Marx, CM, & Blumer, JL (1992). Assessing distress in pediatric intensive care environments: the COMFORT scale. Journal of Pediatric Psychology, 17(1): 95-109.
- B. Beyer, JE, Villarruel, AM, & Denyes, MJ. (1995). The ouch user's manual and technical report.
- C. Feldt, KS. (2000). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing, 1(1): 13-21.
- D. Gregg, TL. (1998). Pediatric pain management in an adult critical care unit. Critical Care Nurse Quarterly, 21(2): 42-54.
- E. Jacobi, J., Fraser, GL, Coursin, DB and others. (2002). Clinical practice guidelines for the sustained use of sedatives and analgesics in the critically ill adult. Critical Care Medicine, 30(1): 119-141.
- F. Krechel, SW & Bildner J. (1995). CRIES: a new neonatal postoperative pain measurement score – initial testing of validity and reliability. Paediatric Anaesthesia, 5: 53-61.
- G. Li, JM. (2002). Pain management in the hospitalized patient. Medical Clinics of North America, 86: 771-795.
- H. McCaffery, M. & Pasero, C. (2001). Assessment and treatment of patients with mental illness. American Journal of Nursing, 101(7): 69-70.
- I. McCaffery, M. and Beebe, A. (1993). Pain: Clinical manual for nursing practice. Baltimore: C.V. Mosby Company.
- J. Merkel, SI, Voepel-Lewis, T, Shayevitz, JR, & Malviya, S. (1997). The FLACC: a behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23(3): 293-297.
- K. Miaskowski, C. (2001). New approaches for evaluating the quality of cancer pain management in the outpatient setting. Pain Management Nursing, 2(1): 7-12.
- L. Miaskowski, C. (1993). Current concepts in the assessment and management of cancer-related pain. Med-Surg Nursing 2(2): 113-118.
- M. Peden, V & Saddington, C. (2001). Using the ouch scale. Paediatric Nursing, 13(3): 24-26.
- N. Summers, S. (2001). Evidence-based practice part 2: Reliability and validity of selected acute pain instruments. Journal of PeriAnesthesia Nursing, 16(1): 35-40.
- O. Tyler, DC, TU, A, Douthit, J, & Chapman, CR. (1993). Toward validation of pain measurement tools for children: a pilot study. Pain, 52: 301-309.
- P. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., & Malviya, S. (2002). The reliability and validity of the face, legs, activity, cry, consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia Analgesia, 95: 1224-1229.
- Q. Wong, D & Whaley, L. (1986). Clinical handbook of pediatric nursing, ed., 2, p. 373. St. Louis: C.V. Mosby Company.
- R. Wong, DL & Baker, CM. (1988). Pain in children: comparison of assessment scales. Pediatric Nursing, 14(1): 9-17.

Approved:

Clare Hastings, R.N., Ph.D
Chief, Nursing and Patient Care Services

Formulated: April 2003
Implemented: July 2003
Revised: June 2003; 11/2003